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February 21, 2013

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS 2334-P
P.O. Box 8010
Baltimore, Maryland 21244-8010

Re: CMS 2334-P, Patient Protection and Affordable Care Act; Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearings, and Appeal Processes for Medicaid and Exchange Eligibility Appeals, Other Provisions Related to Eligibility and Enrollment, and Medicaid Premiums and Cost-Sharing; Proposed Rule

Dear Administrator Tavenner:

The Silver State Exchange appreciates the opportunity to comment on proposed rule CMS-2334-P published in the Federal Register[1] on January 22, 2013 outlining essential health benefits under alternative benefit plans for Medicaid beneficiaries; notice, fair hearing, and appeals processes for Medicaid and Exchange eligibility appeals; other provisions related to eligibility and enrollment; and Medicaid premiums and cost-sharing provisions.

We support many of the proposals in the rule and appreciate the flexibility provided. However, in our attempt to keep costs as low as possible while providing the excellent customer service that Nevadans deserve, we respectfully request additional flexibility in a few key areas of the regulation. Additionally, we request careful consideration of enrollment rules that could lead to increases in fraud and result in increased premiums. To that end we provide the following comments.

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42 CFR § 431.10 SINGLE STATE AGENCY

The proposed rule would allow Medicaid/CHIP agencies to delegate eligibility determinations, informal dispute resolution, appeals, and hearings to the Exchange under a written agreement. The proposed Medicaid rule at 42 CFR § 431.10(c)(2) rule would reverse a provision in an earlier Medicaid rule and would allow Medicaid delegations of authority to the Exchange only if the Exchange is a governmental agency (including a public authority) that maintains merit protections for its employees. The Silver State Exchange is an agency of the State of Nevada that would be qualified to enter into written agreements with the State Medicaid agency under

[1] Federal Register, Vol. 78, No. 14, Tuesday, January 22, 2013, Proposed Rules, pp. 4594-4724

the proposed rule. We support the flexibility that continues to be afforded to both State agencies under the proposed rule.

42 CFR § 431.205 PROVISION OF HEARING SYSTEM

We support the allowance to have a hearing before the Exchange as provided under 42 CFR § 431.205(b)(1)(ii). However, should the state determine that appeals be handled under the Exchange entity, that decision would likely be the result of a desire to create one organization that handles eligibility for health coverage and to implement the no wrong door approach to healthcare. We do not feel it is necessary or appropriate to allow individuals to have the choice to have their hearing conducted at either the Medicaid agency or the Exchange entity. This will prohibit the state from taking advantages of the efficiencies created by allowing the Exchange to conduct all enrollment appeals. The decision should be left to the State. We recommend striking the language, "provided that individuals who have requested a fair hearing are given the choice to have their fair hearing conducted by the agency or the Exchange or Exchange appeals."

45 CFR § 155.225 CERTIFIED APPLICATION COUNSELORS

45 CFR § 155.225 requires that the Exchange must certify staff and volunteers of Exchange-designated organizations and organizations designated by the state Medicaid and CHIP agencies to act as Certified Application Counselors (CACs). The Exchange must certify an individual who registers with the Exchange, is trained, discloses potential conflicts of interest, complies with Exchange privacy and security standards as well as authentication and data security standards, complies with applicable state laws, and provides information with reasonable accommodations for persons with disabilities within the meaning of the Americans with Disabilities Act (ADA). The proposed rule also states that certified application counselors may not impose any charges on applicants for application assistance.

We support the use of CACs to assist individuals enroll in Medicaid, CHIP and QHPs through the Exchange. Additionally we support the flexibility provided in the regulation to allow the State to determine the most appropriate methods to certify CACs. We are concerned about the language in 45 CFR § 155.225(a) that requires the Exchange to certify staff and volunteers of Exchange-designated organizations and organizations designated by the state Medicaid and CHIP agencies without regard to whether such individuals meet the standards of certification provided in 155.225(b). Therefore, we recommend adding, "provided such individuals meet the standards of certification provided in paragraph (b)," after "…42 CFR 435.908 to act as application counselors…"

45 CFR 155.227 AUTHORIZED REPRESENTATIVES

The proposed rule provides that the Exchange must permit an individual or employee to designate an individual or an organization to act on his behalf. Such designation must be in writing, including a signature or "another legally binding format subject to applicable authentication and data security standards."

The proposed rule provides that the Exchange must ensure that the authorized representative "agrees to maintain, or be legally bound to maintain, the confidentiality of any information." The proposed rule further provides that the Exchange "ensures the authorized representative is responsible for fulfilling all responsibilities within the scope of the authorized representative." Finally, the rules requires the duration of the designation be valid until the applicant modifies the authorization or notifies the Exchange that the designation is no longer valid or the authorized representative informs the Exchange and the individual that the representative is no longer acting in such capacity.

We recommend that the requirement at 45 CFR § 155.227(a)(3) that "The Exchange ensures the authorized representative agrees to maintain, or be legally bound to maintain, the confidentiality of any information…" be rephrased as "The authorized representative shall agree in writing, in a form or manner determined by the Exchange, to maintain the confidentiality of any information…" to make it abundantly clear that it is the legal duty of the authorized representative to maintain confidentiality in daily practice after giving proper assurances to the Exchange. We ask that CMS confirm in the final rule that the Exchange should not be deemed liable in any manner for any breeches of confidentiality that are beyond the control of the Exchange.

We recommend that the requirement at 45 CFR § 155.227(a)(4) that "The Exchange ensures the authorized representative is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representative" be rephrased as "The authorized representative shall agree in writing, in a form or manner determined by the Exchange, to fulfill his responsibilities to the applicant and the Exchange" to make it abundantly clear that it is the legal duty of the authorized representative to fulfill his responsibilities in daily practice after giving appropriate assurances to the Exchange. As in the preceding item, we ask that CMS confirm in the final rule that the Exchange should not be deemed liable for any failures of authorized representatives to fulfill any responsibilities of authorized representatives where such failures are beyond the control of the Exchange.

We agree with the limits to the duration of a designation as provided in 45 CFR § 155.227(d). However, we recommend that Exchanges be provided additional flexibility to terminate such a designation after a given period of time. We feel this aligns with five year limitation for authorizations from individuals to allow Exchanges to accept federal tax information for the purpose of conducting redeterminations. We request such language allow the Exchange to determine the period of time for which a designation is active.

45 CFR § 155.227(e) requires that if an organization is designated as an authorized representative, the organization and its staff or volunteers must enter into an agreement to comply with the requirements of 45 CFR § 155.225(b) regarding standards of certification for Certified Application Counselors. The preamble appears to indicate that the protections provided in the standards of certification for Certified Application Counselors are focused on disclosure, compliance with privacy and security and other agreements. However, 45 CFR §

155.225(b)(2) requires training as a CAC. We seek clarity regarding whether it is the intent of CMS to require that staff or volunteers of organizations must be trained as CACs.

Additionally, consistent with the additional language provided in the paragraphs above, we recommend inserting language into 45 CFR § 155.227(e) to allow the Exchange to dictate the form or manner of the authorization.

45 CFR § 155.315 VERIFICATION PROCESS RELATED TO ELIGIBILITY FOR ENROLLMENT IN A QHP THROUGH THE EXCHANGE

45 CFR § 155.315 applies to the resolution of inconsistencies between an individual's attestation of certain eligibility information and a data source available to the Exchange. If the individual's attestation is inconsistent with the data source available to the Exchange, 45 CFR § 155.315(f)(4) requires the Exchange provide eligibility for enrollment in a QHP, APTC and CSR, as applicable, based on all other data elements in the application and assuming the attestation is correct. An individual may remain on such coverage for 90 days without resolution of inconsistencies. We are concerned that an individual who is enrolled in coverage for 90 days and receiving APTC and CSR may not, in fact, be eligible for such coverage.

If a person is enrolled in a QHP with APTC, the QHP is expected to pay claims in good faith. Additionally, that carrier expects to receive payment, in the form of premium payment from the individual and APTC from CMS. If the Exchange later determines that the individual is not eligible (the inconsistency is not resolved), we are concerned that the notification of ineligibility will result in CMS attempting to recover the APTC from the carrier which will result in much higher premiums within the Exchange when compared to non-QHP products sold outside the Exchange. Furthermore, we are concerned that, if the inconsistency is due to validation of a social security number, citizenship or another item and that individual does not pay taxes, it may be impossible for the IRS to recover funds. This section invites fraud and provides no protections to the market or the tax payer.

We recommend that an individual be afforded 30 days to provide the Exchange with evidence supporting the individual's attestation regarding a data element that is inconsistent with another data source. If such evidence supports the information on the application, the Exchange shall proceed with the enrollment. Furthermore, we recommend that an enrollment in a QHP, APTC and CSR be prospective on the first of the month following receipt of such evidence.

45 CFR § 155.345 COORDINATION WITH MEDICAID, CHIP, THE BASIC HEALTH PROGRAM, AND THE PRE-EXISTING CONDITION INSURANCE PLAN

45 CFR § 155.345(a)(3)(ii) indicates that an eligibility "…notice will be issued by the last agency to determine the individual's eligibility except for eligibility for Medicaid based on standards other than those specified in § 155.305(c)…" While we agree with the requirements to provide such notices, we feel it is necessary to allow the state to determine the best agency to provide such notices. We recommend striking the language, "will be issued by the last agency to

determine the individual's eligibility except for eligibility for Medicaid based on standards other than those specified in § 155.305(c), regardless of which agency receives the application, and"

45 CFR § 155.510 APPEALS COORDINATION

45 CFR § 155.510 requires that an appellant must have the option to appeal an adverse Medicaid or CHIP determination made by the Exchange directly to Medicaid or CHIP. It also requires that appellants have the opportunity to appeal directly to Medicaid or CHIP. However, should the state determine that appeals be handled under the Exchange entity, that decision would likely be the result of a desire to create one organization that handles eligibility for health coverage and to implement the no wrong door approach to healthcare. We do not feel it is necessary or appropriate to allow individuals to have the choice to have their hearing conducted at either the Medicaid agency or the Exchange entity. This will prohibit the state from taking advantages of the efficiencies created by allowing the Exchange to conduct all enrollment appeals. The decision should be left to the State.

The proposed rule provides that the appeals entity or the Exchange must enter into agreements with the agencies administering insurance affordability programs regarding the coordination of appeals for such programs. We recommend that CMS make available an agreement template that the Exchange may, at its option, adopt or revise in order to fulfill the requirements of the proposed rule. Such an agreement template would be helpful as long as the Exchange has the flexibility to revise it as State-specific circumstances require.

45 CFR § 155.525 ELIGIBILITY PENDING APPEAL

45 CFR § 155.525 requires an Exchange continue enrollment in a QHP, APTC and CSR for an individual who has appealed a determination. We are concerned that an individual who is enrolled in coverage for the length of the appeals process and receiving APTC and CSR may not, in fact, be eligible for such coverage. While we intend to administer appeals promptly, we are concerned about the ability of HHS to do so.

If a person is enrolled in a QHP with APTC, the QHP is expected to pay claims in good faith. Additionally, that carrier expects to receive payment, in the form of premium payment from the individual and APTC from CMS. If the Exchange later determines that the individual is not eligible (the inconsistency is not resolved), we are concerned that the notification of ineligibility will result in CMS attempting to recover the APTC from the carrier which will result in much higher premiums within the Exchange when compared to non-QHP products sold outside the Exchange. Furthermore, we are concerned that, if the adverse enrollment determination is due to a problem with a social security number, citizenship or another item and that individual does not pay taxes, it may be impossible for the IRS to recover funds. This section invites fraud and provides no protections to the market or the tax payer.

An adverse enrollment determination would only be made with good reason. Therefore, we recommend that an enrollment in a QHP, APTC and CSR only occur after an adverse enrollment

determination is overturned during the appeals process and the effective date of enrollment be retroactive to the date the person would have initially been eligible for coverage.

45 CFR § 155.535 INFORMAL RESOLUTION AND HEARING REQUIREMENTS & 45 CFR § 155.555 EMPLOYER APPEALS PROCESS

The proposed rule provides at 45 CFR § 155.535(c) that all hearings must be conducted by one or more impartial officials who have not been directly involved in the eligibility determination or any prior Exchange decisions "in the same matter." We are concerned that the exact meaning of "in the same matter" could become a point of legal dispute in subsequent judicial reviews of hearing decisions under the proposed rule. It could lead to Exchange decisions being overturned in court on strictly procedural grounds just because an official was in some arguable way involved in a prior Exchange decision "in the same matter." We recommend that the proposed rule simply state that all hearings must be conducted by one or more impartial officials who have not been directly involved in the eligibility determination.

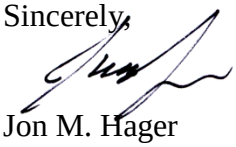
Similarly, the language in 45 CFR § 155.555(i) on the review of employer appeals by one or more impartial officials who have not been directly involved in the eligibility determination "implicated in the appeal" could also become a point of legal dispute in subsequent judicial reviews. "Implicated in the appeal" may be less subject to dispute than "in the same matter" but, for the same reasons as in the above item, we again recommend that the proposed rule simply state that all hearings must be conducted by one or more impartial officials who have not been directly involved in the eligibility determination.

The proposed rule provides at 45 CFR § 155.535(f) that the appeals entity will review the appeal *de novo* and will consider all relevant facts and evidence adduced during the appeal. *De novo* review is defined at 45 CFR § 155.500 as review of an appeal without deference to prior decisions in the case. However, there may be instances where the appeals entity finds that deference to a prior decision would be appropriate and a *de novo* hearing would not be needed.

To reduce any unnecessary appeals burden and the costs of legal process, we recommend that 45 CFR § 155.535 indicate that the appeals entity should review the appeal *de novo*, unless the appeals entity determines that a *de novo* hearing is not needed. We recommend the same language, for similar reasons, in 45 CFR § 155.555(i)(3) concerning the employer appeals process.

We appreciate the opportunity to offer these comments and look forward to working with you further on these and other health insurance exchange implementation activities.
Thank you very much for considering our input.

Sincerely,



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cc: Jackie Bryant, Deputy Chief of Staff, Office of the Governor
Mike Willden, Director, Department of Health and Human Services
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